Department of Veterans Affairs
Health Administration Center
CHAMPVA

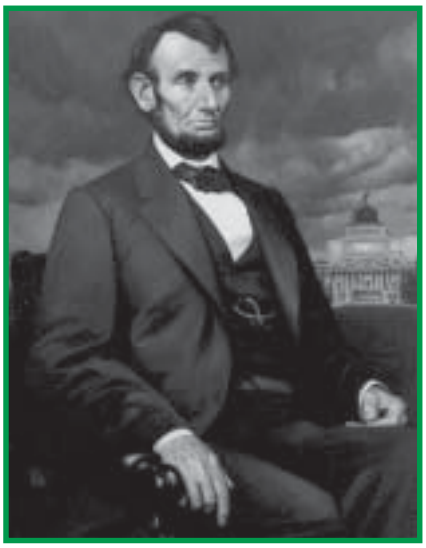
CHAMPVA

2002 Handbook

Change of address or phone number?

Stay on our mailing list… promptly report any change of address to VA's Health Administration Center
PO Box 65023
Denver, CO 80206-9023
E-mail: hac.inq@med.va.gov

In addition, as we do much of our business over the phone, please keep us informed of any and all changes to your telephone number(s).



“To care for him who shall have
borne the battle, and for his
widow, and his orphan”

Abraham Lincoln

“Lincoln” by Richard Miller, oil on canvas 40”X30” http://www.richardmiller.com

Notice of intent to conduct computer matching: Public Law 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches. Pursuant to 5 USC 552a, the Privacy Act of 1974, as amended, and the Office of Management and Budget Guidelines on the Conduct of Matching Programs, notice is hereby given of the VA's intent to conduct computer matches with Centers for Medicare and Medicaid Services (CMS). Data from the proposed matches will be utilized to verify Medicare entitlement for applicants and recipients for CHAMPVA benefits, whose eligibility for CHAMPVA is based upon entitlement for Medicare.

Table of Contents

General Information

Department of Veterans Affairs
Health Administration Center
CHAMPVA

Overview

What is the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)?

CHAMPVA is a health benefits program in which the Department of Veterans Affairs (VA) shares the cost of certain health care services and supplies with eligible beneficiaries (see *Eligibility* for criteria for CHAMPVA coverage). CHAMPVA is managed by the VA's Health Administration Center (HAC) in Denver, Colorado. We process CHAMPVA applications, determine eligibility, authorize benefits, and process medical claims. We strongly recommend that all your inquiries about CHAMPVA be made directly to us.

What is the relationship between CHAMPVA and TRICARE?

Both are federal programs, however, an individual who is eligible for TRICARE is not eligible for CHAMPVA. Although similar, TRICARE (formerly CHAMPUS - which is administered by the Department of Defense) should not be confused with CHAMPVA. TRICARE provides coverage to the families of active duty service members, families of service members who died while on active duty, and retirees and their families, whether or not the veteran is disabled.

What is the relationship between CHAMPVA and Medicare?

Both are federal programs, however, CHAMPVA is always the last payer after Medicare and any other health insurance (OHI). An exception to this is when you reside or travel overseas. When that is the case, if you meet all eligibility criteria, CHAMPVA will be the primary payer (unless you have other health insurance) until you return to the U.S. Refer to the section entitled *Rules that Impact Eligibility* for information regarding CHAMPVA eligibility when there is also Medicare entitlement.

Assistance

If you need assistance, there are four ways to contact us:

- **Mail:** **VA Health Administration Center**
  CHAMPVA
  PO Box 65023
  Denver, CO 80206-9023

If you wish to write us, please state the nature of your inquiry, the name of the beneficiary (if you are not the beneficiary), the CHAMPVA Authorization Card number (Social Security Number), and a phone number.

- **Phone:** **1-800-733-8387**

Telephone assistance is available (toll free) by calling us between the hours of 8:15 a.m. - 6:00 p.m. (Eastern Time), Monday through Friday (holidays excluded) to speak with a Benefits Advisor. You may also use our automated menu that is available 24 hours a day, 7 days a week, to request applications, claim forms, and other CHAMPVA material. Once you are familiar with our automated services, please consider using them during non-business hours.

- **FAX:** **1-303-331-7804**

When using our 24-hour FAX service, please state the nature of your inquiry, the name of the beneficiary (if you are not the beneficiary), and the CHAMPVA Authorization Card number (same as your Social Security Number). FAX messages that simply ask for a return call, unfortunately, cannot be honored.

- **E-mail** **hac.inq@med.va.gov**

If you wish to e-mail us, please state the nature of the inquiry and the name of the beneficiary (if you are not the beneficiary) in your e-mail inquiry and we will respond as quickly as possible.

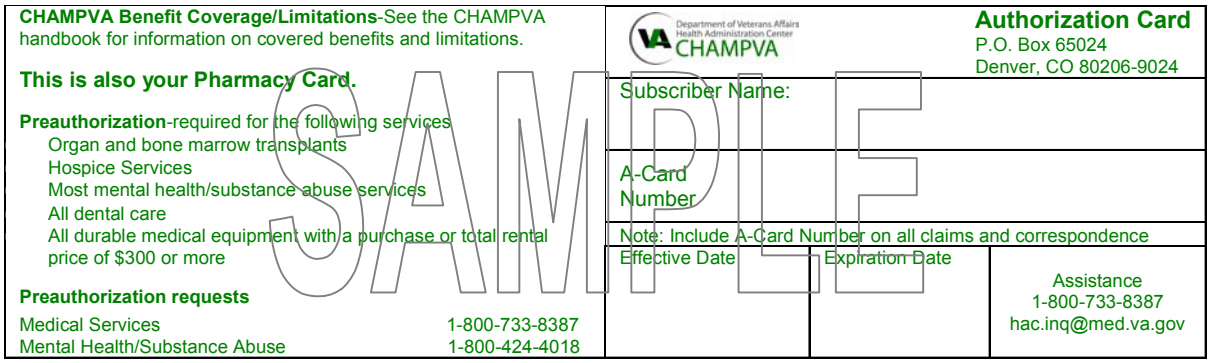
Information regarding CHAMPVA benefits can also be obtained from fact sheets available at www.va.gov/hac or by calling 1-800-733-8387. A listing of all CHAMPVA fact sheets is included in the back of this handbook.

Change of Telephone Number or Address:
Help us stay in touch! Please notify us of any change of address or telephone numbers.

Application for Benefits

General Information:

An application (VA Form 10-10d) must be submitted to us before you or your physician submits bills for health care services. You must have a Social Security Number (SSN) for each individual on the application, including newborns. If you need an SSN for a member of your family, contact your nearest Social Security Office. After your application is processed, we will mail a CHAMPVA Authorization Card (A-Card) to each authorized family member.



The Application Process:

To apply for benefits, send the following information to the HAC, CHAMPVA-Eligibility, PO Box 469028, Denver, CO 80246-9028. Forms are available from the voice mail menu at 1-800-733-8387, 24 hours a day, 7 days per week. Please consider placing calls for an application form during evening or weekend hours. You may also obtain the necessary forms from our website at www.va.gov/hac by selecting FORMS from the left panel.

- VA Form 10-10d, Application for CHAMPVA Benefits
- VA Form 10-7959c, CHAMPVA Other Health Insurance Certification
- A copy of your Medicare card if you are also eligible for Medicare
- A copy of the veteran's DD 214 Form, Certificate of Release or Discharge from Active Duty (or Report of Separation for WWII and Korean era veterans). If you cannot find this form, send in your application without it. We will obtain one from the VA Regional Office.

Federal law requires that family members of the veteran be legal dependents. The relationship of the veteran to the individual applying for CHAMPVA benefits will be verified with the VA Regional Office. If you have not previously contacted the VA Regional Office to establish your legal relationship to the veteran, you should do so prior to applying for CHAMPVA. Once you have done so, submit your application for CHAMPVA benefits to us. To reduce the time it takes to process your application, we recommend you also send a copy (never the original) of the following documents that are applicable to you with your application. These documents do not need to be notarized. If the documents are included with your application and the forms are filled out correctly, it normally takes 45 days to process your application from the date it is received.

Documentation	When Needed
The Department of Veterans Affairs (VA) rating decision	• Qualifying sponsor is permanently and totally disabled due to a service-connected disability • Qualifying sponsor died as a result of a service-connected condition or was permanently and totally disabled at the time of death
The casualty report	• Qualifying sponsor died on active duty
Marriage license/certificate	• Spouse/widow(er) applications
Birth certificate	• Dependent children applications (birth, adopted, stepchildren)
Adoption court order	• Adopted children
School certification letter	• Dependent children between the ages of 18 and 23

Eligibility

Eligibility Definitions:

- Beneficiary: a CHAMPVA-eligible spouse, widow(er), or child.
- Child: includes birth, adopted, stepchild, or helpless child as determined by a VA Regional Office (see the *Rules that Impact CHAMPVA Eligibility* section of this handbook).
- Dependents: a child, spouse, or widow(er) of a qualifying sponsor.
- Sponsor: a veteran who is permanently and totally disabled from a service-connected condition, died as a result of a service-connected condition, was rated permanently and totally disabled from a service-connected condition at the time of death, or died on active duty and whose dependents are not otherwise entitled to DoD TRICARE benefits.
- Service-connected: a VA Regional Office determination that a veteran's illness or injury is related to military service.
- Spouse: the wife or husband of a qualifying sponsor.
- Widow(er): the surviving spouse of a sponsor who died as a result of a service-connected condition, was rated permanently and totally disabled from a service-connected condition at the time of death, or died on active duty and is not otherwise entitled to DoD TRICARE benefits.

Who is Eligible for CHAMPVA: CHAMPVA provides coverage to the spouse or widow(er) and to the children of a veteran who:

- is rated permanently and totally disabled due to a service-connected disability, or
- was rated permanently and totally disabled due to a service-connected condition at the time of death, or
- died of a service-connected disability, or
- died on active duty and the dependents are not otherwise eligible for DoD TRICARE benefits.

CHAMPVA eligibility can be impacted by changes such as marriage, divorce from the sponsor, or eligibility for Medicare or TRICARE. Changes in status should be reported immediately to CHAMPVA, ATTN: Eligibility Unit, PO Box 469028, Denver, CO 80246-9028 or call 1-800-733-8387.

Rules that Impact CHAMPVA Eligibility

CHILD

Ending Date for a Child's Eligibility: Eligibility for CHAMPVA ends when:

- a child turns 18 unless enrolled in an accredited school as a full-time student,
- a child, who has been a full-time student, turns 23,
- a child marries (as of midnight on the date of marriage), or
- a stepchild no longer lives in household of the sponsor.

Student Status: To establish student status and retain CHAMPVA eligibility, a child must be between the ages of 18 and 23 and attend school full time. Schools may include high school; vocational or technical school; junior colleges; and colleges and universities that are accredited by a nationally recognized agency or association. Student status may be established for up to a full year with a letter from the school certifying the beginning and ending dates of the school terms for which the student has pre-enrolled as a full-time student. Certifications submitted in a foreign language are acceptable, however, additional time will be required for translation.

- School certifications must be submitted on school letterhead. They can be submitted by mail to CHAMPVA, PO Box 469028, Denver, CO 80246-9028 or by FAX to 1-303-331-7809 and must include the following information:
  - student's full name,
  - student's Social Security Number (SSN),
  - exact beginning and ending dates of each semester or enrollment term,
  - number of semester hours or equivalent (high schools excluded) certifying full-time status, and
  - title and signature of a school official.

- Full-time attendance is defined as twelve semester credit hours for spring or fall semesters or the equivalent number of hours on a quarter-based academic calendar (rather than semesters).

- Summer breaks are not considered an interruption in full-time school attendance when the student is enrolled full-time in the semester (or quarter) prior to the summer break and pre-enrolled full time in the semester (or quarter) following summer break or the student is enrolled full-time in the summer semester (or quarter) as verified by the educational institution.

- If a student withdraws from school during the semester (or quarter), full-time school status is not established and CHAMPVA eligibility will be discontinued.

- If a student incurs a disabling illness or injury while enrolled as a full-time student, eligibility may continue for six months after the disability ceases, for two years after the onset of the disability, or until the 23rd birthday—whichever occurs first. Medical documentation is required to support that the illness or injury is of a disabling nature and prevents the child from attending school.

Impact of Divorce or Remarriage of Spouse on Child's Eligibility: The eligibility of a child is not affected by the divorce or remarriage of the spouse except in the case of a stepchild. When a stepchild leaves the sponsor's household, the child is no longer eligible for CHAMPVA.

Helpless Child: A child who, before the age of 18, became permanently incapable of self-support and was rated as a helpless child by a VA Regional Office, is eligible for CHAMPVA with no age limitation.

SPOUSE

Eligibility for CHAMPVA ends with termination of the marriage to the qualifying sponsor by annulment or divorce. CHAMPVA eligibility terminates as of midnight on the effective date of the dissolution of the marriage, as stated in the annulment or divorce decree.

WIDOW(ER)

Remarriage: Eligibility for CHAMPVA ends if the widow(er) remarries. CHAMPVA eligibility terminates at midnight on the date of the remarriage.

Termination of Remarriage: A widow(er) of a qualifying sponsor who remarries and the remarriage is later terminated by death, divorce, or annulment may establish CHAMPVA eligibility. The beginning date of eligibility is the first day of the month after termination of the remarriage or December 1, 1999, whichever date is later. To reestablish CHAMPVA eligibility, copies of the marriage certificate and death, divorce, or annulment documents (as appropriate) must be provided.

MEDICARE ENTITLEMENT

As a result of a Federal law passed June 5, 2001, expanded benefit coverage is available to CHAMPVA eligible family members and survivors, over age 65, effective October 1, 2001.

If you are eligible for CHAMPVA and also have Medicare Part A entitlement (premium-free hospitalization coverage) and Medicare Part B (outpatient coverage) we will cover many of the costs not covered by Medicare. There are limitations if you have only Medicare Part A entitlement, so please read the following criteria to determine whether you meet the eligibility requirements for CHAMPVA when you also have Medicare entitlement.

Important Facts to Remember:

- If you have Medicare Part A entitlement and you have Part B, **do not terminate your Medicare Part B coverage**. You must continue to carry Part B for CHAMPVA eligibility.
- If you are under age 65 and entitled to Medicare Part A, or your 65th birthday was on or after June 5, 2001, **you must be enrolled in Medicare Part B** to have CHAMPVA eligibility.
- If Part B is a requirement for you to have CHAMPVA eligibility, and you are not currently enrolled, contact your local Social Security Administration (SSA) office to enroll.

The following chart and narrative explain when you must enroll in Medicare Part B to be eligible for CHAMPVA.

	Is Medicare Part B Required for CHAMPVA eligibility?
Under age 65 and entitled to Part A	Yes
65 or older prior to June 5, 2001, with only Medicare Part A coverage	No
65 or older prior to June 5, 2001, with Medicare Part A coverage and enrolled in Part B as of June 5, 2001	Yes
65 or older on or after June 5, 2001, and entitled to Medicare Part A	Yes

Under age 65:

- If you have both Medicare Parts A and B, CHAMPVA will pay after Medicare and any other insurance, such as Medicare HMOs and Medicare supplemental plans, for health care services and supplies.

- If you are entitled to Medicare Part A and are not enrolled in Medicare Part B, you are not eligible for CHAMPVA. If you later enroll in Medicare Part B, you may apply for CHAMPVA at that time. In that case, CHAMPVA eligibility will begin on the effective date of your Medicare Part B coverage.

Age 65 or older:

- If you are over age 65, meet the criteria for CHAMPVA eligibility (see the section entitled *Eligibility* in this handbook), and are not entitled to Medicare Part A**,** either under your own or a former spouse's Social Security Number, you are CHAMPVA eligible.

    - If you are not entitled to Part A of Medicare, you must submit a Social Security Administration "Notice of Disallowance" with your application.

    - If you have Medicare Part A through the Premium-HI provisions (available when you do not have eligibility for premium-free Medicare Part A, but obtain Part A coverage through a non-federal financed source) a copy of your Medicare card or other official documentation noting this must be provided.

    - If you have purchased Part B of Medicare, but are not entitled to Part A, a copy of your Medicare card or other official documentation noting this must be provided.

- Age 65 or older prior to June 5, 2001:

    - If you were age 65 prior to June 5, 2001, are entitled to Medicare Part A, and are not enrolled in Medicare Part B, you are eligible for CHAMPVA. If you did not enroll in Medicare Part B prior to June 5, 2001, you are not required to do so. Medicare will pay first for all services covered under Part A, and CHAMPVA will pay after Medicare (and any other health insurance you may have) for medical services received on or after October 1, 2001. CHAMPVA will be the primary payer (first payer) for covered outpatient services unless you have other health insurance for outpatient care. If that is the case, CHAMPVA will be the secondary payer (paying after the other health insurance has made payment).

- If you were age 65 prior to June 5, 2001, are entitled to Medicare Part A, and enrolled in Medicare Part B, you are eligible for CHAMPVA. However, you must continue to carry Medicare Part B to retain CHAMPVA eligibility. CHAMPVA will pay after Medicare (and any other health insurance you may have to include Medicare HMOs and Medicare supplemental plans) for covered medical services received on or after October 1, 2001.

• Age 65 between June 5, 2001, and prior to October 1, 2001:

  - If you became age 65 between these dates and are entitled to Medicare Part A, you must be enrolled in Medicare Part B, to be CHAMPVA eligible for medical services on or after October 1, 2001. CHAMPVA will pay after Medicare (and any other health insurance you may have to include Medicare HMOs and Medicare supplemental insurance plans) for covered medical services.

  - If you became age 65 between these dates and are entitled to Medicare Part A, but did NOT enroll in Medicare Part B, you are not eligible for CHAMPVA. If you later enroll in Medicare Part B, you may apply for CHAMPVA at that time. In that case, CHAMPVA eligibility will begin on the effective date of your Medicare Part B coverage.

• Age 65 on or after October 1, 2001:

  - If you become age 65 after October 1, 2001, are entitled to Medicare Part A and enrolled in Medicare Part B, you are eligible for CHAMPVA. CHAMPVA will pay after Medicare (and any other health insurance you may have to include Medicare HMOs and Medicare supplemental insurance plans) for covered medical services received on or after the date your Medicare Parts A and B coverage begins.

  - If you become age 65, are entitled to Medicare Part A, but are NOT enrolled in Medicare Part B, you are not eligible for CHAMPVA. If you later enroll in Medicare Part B, you may apply for CHAMPVA at that time. In that case, CHAMPVA eligibility will begin on the effective date of your Medicare Part B coverage.

Help Fight Fraud

Combating fraud and abuse takes a cooperative effort from each of us. One way for you to help is by reviewing your Explanation of Benefits to be sure that the services billed to us were reported properly. If you should see a service and/or supply billed to us that you did not receive, please report that immediately in writing. Indicate in your letter that you are filing a fraud complaint and document the following facts:

- The name and address of the provider,
- The name of the beneficiary who was listed as receiving the service or item,
- The claim number,
- The date of the service in question,
- The service or item that you do not believe was provided,
- The reason why you believe the claim should not have been paid, and
- Any additional information or facts showing that the claim should not have been paid.

DETECTION TIPS

You should be suspicious of practices that involve:

- Providers who routinely do not collect your cost share (co-payment).
- Billing by your provider for services that you did not receive.
- Providers billing for services or supplies that are different from what you received.

PREVENTION TIPS

- Always protect your CHAMPVA card. Know who you are giving your ID number to. Do not provide your ID number to someone over the phone.
- Be skeptical of providers who tell you that a particular item or service is not usually covered by CHAMPVA, but knows how to bill for the item or service to get it paid.

Benefit Information

Department of Veterans Affairs
Health Administration Center
CHAMPVA

Overview

In general, CHAMPVA covers most health care services and supplies that are medically necessary. Special rules and/or limitations do apply to certain services. Some services (even when prescribed by a physician) are not covered under CHAMPVA. Be aware that this handbook does not cover all CHAMPVA policies and the benefits may change over time. Clarification of covered/noncovered services, as well as limitations, can be obtained by calling us at 1-800-733-8387 or e-mailing us at hac.inq@med.va.gov. You can also visit our website at www.va.gov/hac.

HEALTH CARE PROVIDERS

You have many choices in selecting a provider, but be sure the provider is properly licensed in your state and is not on the Medicare exclusion list. CHAMPVA will pay for covered services and supplies (note limitations for some services described in this handbook), including those needed for pre-existing conditions, when received from these professional providers. In the case of physician assistants, some counselors, anesthetists, audiologists, and therapists there is a requirement that the services be supervised (overseen) by the physician. Here is a list of most of the providers covered by CHAMPVA (not all inclusive).

- Anesthetist
- Audiologist
- Certified Midwife
- Certified Nurse Anesthetist (CRNA)
- Certified Nurse Practitioner
- Certified Physician Assistant
- Certified Psychiatric Nurse Specialist
- Clinical Psychologist
- Clinical Social Worker
- Dentist (when services are a covered benefit and preauthorized)
- Family Counselor/Therapist
- Licensed Clinical Social Worker (Masters Level)
- Licensed Practical Nurse (LPN)
- Licensed Vocational Nurse (LVN)
- Medical Doctor (MD)
- Occupational Therapist
- Osteopath (DO)
- Pastoral Counselor
- Physical Therapist
- Physician (Medical Doctor, MD)
- Podiatrist

- Psychiatrist
- Physiologist
- Registered Nurse

Services from the following types of providers are not payable under CHAMPVA:

- Acupuncturist
- Chiropractor
- Naturopath

CHAMPVA does not maintain a provider listing. If you need to find a provider, we recommend you go to the TRICARE website at www.tricare.osd.mil to search for a provider in your area. From the pull-down menu, select *Provider Directory* and then select *TRICARE Standard*. Most TRICARE providers will also accept CHAMPVA, but be sure you ask the provider. If you wish to see a provider who does not accept CHAMPVA, you will likely have to pay for the care received and then file a claim with CHAMPVA.

VA Providers (CITI):

If there is a VA medical facility in your area, check with them to see if they participate in the CHAMPVA In-house Treatment Initiative (CITI – pronounced *city*) program. CITI is a voluntary program for CHAMPVA beneficiaries. You can receive treatment at VA medical facilities, on a space available basis, with **no cost share or deductible**. There is no enrollment in the CITI program. If the VA medical facility in your area participates in the program and has available services, then you can receive care at that facility.

Most VA medical facilities participate in the CITI program and there is a good chance that a VA medical facility near you is a participant. You can check the CITI website at www.va.gov/hac, select *CHAMPVA,* and then select *CITI* to find a VA medical center near you. You can also call the nearest VA medical facility in your area to see if they participate in the CITI program and the types of medical care that are available to you through their facility. You may also call us at 1-800-733-8387 or contact us at hac.inq@med.va.gov to find out more about this program.

Please remember that the VA medical facility decides whether or not they have capacity to provide care. That decision is not made by CHAMPVA.

The CITI program is not available to beneficiaries with Medicare or with an HMO insurance plan.

Pharmacy Providers:

There are several options available to you for pharmacy services. Please refer to the *Pharmacy Services* section in this handbook for more information.

PREAUTHORIZATION

Certain types of care/services require advance approval, commonly known as preauthorization. This approval or preauthorization is extremely important and the failure to obtain it may result in denial of the claim. The requirements for preauthorization are described in the referenced benefits section.

- Preauthorization is required for:
    - Dental care (see *Dental Services* section)
    - Durable medical equipment with a purchase price or total rental price of $300 or more (see *Durable Medical Equipment* section)
    - Hospice services (see *Hospice* section)
    - Mental health/substance abuse services (see *Mental Health/ Substance Abuse Services* section)
    - Transplants (see *Transplant* section)
- Mental health/substance abuse services do not require preauthorization from our mental health contractor (Magellan) when provided to a beneficiary through the VA CITI Program (see the *Health Care Providers* section of this handbook). If proposed services exceed the allowed benefit, however, medical documentation from the CITI facility must accompany the claim for services and CHAMPVA will review for medical necessity and appropriateness.
- Durable medical equipment provided to a beneficiary through the VA CITI program does not require preauthorization.

PREAUTHORIZATION ASSISTANCE

Contact Information for Dental, Durable Medical Equipment, Hospice, and Transplant Preauthorization Requests

By phone.....	1-800-733-8387 10:00 am – 1:30 pm and 2:30 pm – 4:30 pm Eastern Time Monday through Friday (holidays excluded)
By fax.....	303-331-7807
By mail.....	VA Health Administration Center CHAMPVA ATTN: Preauthorization PO Box 65023 Denver, CO 80206-9023

Contact Information for Mental Health and Substance Abuse Preauthorization Requests

By phone(domestic).....	1-800-424-4018
By phone (international).....	1-720-529-7400 9:00 am – 6:00 pm Eastern Time Monday through Friday (holidays excluded)
By fax.....	1-800-424-4017
By mail.....	Magellan Behavioral Health CHAMPVA PO Box 3567 Englewood, CO 80155

GENERAL EXCLUSIONS

CHAMPVA does not cover these items. In addition to these general exclusions, the benefit descriptions in this handbook provide more detail regarding non-covered services.

- Services and supplies obtained as part of a grant, study, or research program.
- Services and supplies not provided in accordance with accepted professional medical standards or related to experimental/investigational or unproven procedures or treatment regimens.
- Care for which you are not obligated to pay, such as services obtained at a health fair.
- Care provided outside the scope of the provider's license or certification.
- Services or supplies above the appropriate level required to provide the necessary medical care.
- Services by providers suspended or sanctioned by any federal agency.
- Services provided by a member of your immediate family or person living in your household.

General Medical Services

What IS Covered (not all-inclusive)

- Allergy testing and treatment (some limitations apply)
  - Bronchial challenge tests
  - IgE immunoassays testing to include, radio allergosorbent tests, fluro allergosorbent tests, and immunoperoxidase assay tests
  - Total serum IgE concentration tests
- Ambulance service when life sustaining equipment is necessary for a medically covered condition or other means of transportation are contraindicated
- Biofeedback to gain some control over autonomic body functions such as cerebral palsy, paralysis, spasm, low back strain (limitations apply—see *What is NOT Covered*)
- Biotelemetry (electronic transmission of data for diagnosis or monitoring)
- Breast reconstruction following a medically necessary mastectomy
- Breast reduction when there are medically indicated signs and symptoms of macromastia or intractable pain, not amenable to other forms of treatment
- Cardiac rehabilitation programs limited to 36 sessions (usually 3 sessions per week for 12 weeks per cardiac event) normally completed within 12 months following a qualifying cardiac event
- CT scans
- Dermatological procedures for the treatment of covered conditions such as acne and for hypertrophic scarring and keloids resulting from burns, surgical procedures, or traumatic events
- Diabetes self-management training program (outpatient) prescribed by a physician (some limitations apply) for education about self-monitoring of blood glucose, diet, and exercise
- Diagnostic tests and procedures for a covered medical condition
- Eyeglasses, spectacles, contact lenses only when medically necessary after intraocular surgery, ocular injury, or congenital absence of a human lens (see *What IS NOT Covered*)
- Foot care services (limited) of a routine nature for a diagnosis of a systemic disease such as diabetes or peripheral vascular disease
- Home health care, to include skilled nursing and rehabilitative care, as part of a physician's treatment plan and provided by a licensed or registered caregiver (Home health care is intermittent skilled care in a home setting when you are homebound. Notes from the caregiver must accompany the claims.)
- Kidney (renal) dialysis limited to periods of Medicare ineligibility (Medicare coverage of individuals with end stage renal disease (ESRD) begins 90 days from the date maintenance dialysis treatment begins at which time CHAMPVA becomes secondary payer)
- Magnetic resonance angiography (MRA), magnetic resonance imaging (MRI), and magnetic resonance spectroscopy (MRS)

- Mastectomy bras and prostheses
  - up to 7 bras every 12 months
  - replacement of breast prostheses every 24 months
- Medical supplies prescribed by a physician and related to a covered medical condition (such as crutches, slings, walkers)
- Occupational therapy (Training and assessment cannot relate primarily to employment.)
- Orthopedic braces and other appliances for the neck, arm, back and leg to assist you in movement or to provide support to a limb (Although preauthorization is not required, claims must be accompanied by a prescription from the attending physician.)
- Orthotic shoes for diabetics:
  - one pair custom molded shoes (including inserts) per calendar year
  - one pair of extra-depth shoes (not including inserts provided with such shoes) per calendar year
  - three pairs of multi-density inserts per calendar year
- Oxygen and related equipment (see *Pharmacy*)
- Penile implant/testicular prosthesis for organic impotence, correction of a congenital anomaly, or correction of ambiguous genitalia
- Physical therapy (physical therapy notes must accompany the claims)
- Physician services
- Positron Emission Tomography (PET) (limitations apply and medical documentation must accompany the claim)
- Prosthetic devices (limited to artificial limbs, voice, and eyes)
- Pulmonary rehabilitation programs limited to pre- and post-operative lung or heart/lung transplants
- Radiation therapy
- Respiratory therapy
- Skilled nursing care (in home) when provided by an individual professional provider for the treatment of a specific illness or condition (Nursing notes must always accompany the claims.)
- Speech therapy for physical impairments to include:
  - brain injury (i.e., traumatic brain injury, stroke/cerebrovascular accident, etc.)
  - congenital anomalies (i.e., cleft lip and cleft palate)
  - neuromuscular disorders such as cerebral palsy
  - sensory disorders (For beneficiaries who are ages 3 to 21, the Individuals with Disabilities Education Act requires these costs to be paid by the State.)
  - dysfunction from a therapeutic process (i.e., vocal cord surgery, radiation therapy, etc.)
  - vocal cord nodules
- Surgically implanted devices for a covered diagnosis
- Wig or hairpiece as a result of treatment for cancer (one per lifetime)

What IS NOT Covered (not all-inclusive)

- Acupuncture
- Air conditioners, humidifiers, dehumidifiers, and purifiers
- Autopsy and post-mortem examinations
- Biofeedback treatment of ordinary muscle tension, psychosomatic conditions, hypertension, urinary incontinence or migraine headaches
- Chemical peeling for facial wrinkles
- Chiropractic services
- Chronic fatigue syndrome
- Cosmetic surgery
- Counseling services for:
  - educational counseling
  - vocational counseling
  - counseling for socioeconomic purposes
  - stress management
  - life style modifications
- Custodial care
- Electrolysis (hair removal)
- Exercise programs (general)
- Eye and hearing examinations (routine)
- Eyeglasses, contact lenses, spectacles or other optical devices except as noted above in “Covered” benefits
- Foot care services of a routine nature, such as removal of corns, calluses, trimming of toenails, except as noted above in “Covered” benefits
- Hair transplants
- Health club membership
- Hearing aids or hearing aid exams
- Housekeeping, homemaker, and attendant services
- Hypnosis
- Medical photography
- Modifications to home or vehicle
- Naturopathic services
- Orthoptics (eye exercises or visual training)
- Orthotic shoe devices, such as heel lifts, arch supports, shoe inserts, etc., unless associated with diabetes
- Penile implant/testicular prosthesis for a psychiatric cause
- Premenstrual syndrome treatment
- Radial keratotomy
- Services or advice provided by telephone
- Tattoo removal
- Transportation services that do not require life sustaining equipment
- Weight control or weight reduction programs

Ambulatory Surgery

Ambulatory surgery is performed on an outpatient, walk-in, or same-day basis in an appropriately equipped and staffed facility. Surgery is usually conducted under general anesthesia with no overnight stay required. CHAMPVA coverage of ambulatory surgical procedures is dependent on where the surgery takes place. Most ambulatory surgical procedures performed in a hospital are covered when medically necessary. Certain procedures are also covered when performed in a Medicare-approved free-standing ambulatory surgical center. If you are scheduled to have a procedure performed in a free-standing surgical center, ask the surgical center if they are Medicare approved to perform the specific procedure.

What IS Covered (not all-inclusive)

In a hospital setting:

- all surgical procedures identified as covered in any section of this handbook
- associated tests (i.e., x-rays, lab tests, etc.)
- facility service
- professional fees such as physician services

In a free-standing ambulatory surgical center:

- professional fees such as physician services
- surgical procedures to be performed safely in a free-standing facility outside of a hospital setting

What IS NOT Covered (not all-inclusive)

If the service is not approved by Medicare to be performed safely outside of a hospital setting, it will not be covered if it is performed in a free-standing ambulatory surgical center. For a listing by procedure of those services that are approved to be performed safely in a free-standing ambulatory setting, refer to the CHAMPVA Policy Manual on our website at www.va.gov/hac, select *CHAMPVA*, then *CHAMPVA Policy Manual,* and then Chapter 3, *Payments, Section 7.1A, Ambulatory Surgical Center (ASC) Reimbursement, Addenda 1.*

Dental Services

With very few exceptions, dental care is ***not*** a covered benefit. There may be times when dental care is covered (as noted below), but in all cases preauthorization is required. Requests for preauthorization must include the following statements:

- Physician statement explaining why the requested dental treatment is required and how it relates to the CHAMPVA-covered medical treatment.
- Dentist statement specifying what treatment is required, why the treatment is required, how it relates to a CHAMPVA-covered medical condition, and the estimated cost.

Preauthorization can be requested by telephone or FAX. See the *Preauthorization* section of this handbook for contact information.

What IS Covered (not all-inclusive)

- Ankyloglossia (total or complete tongue-tie)
- Correction of a cleft palate
- Dental conditions resulting from the treatment of an otherwise covered medical condition (not dental) such as radiation therapy for oral or facial cancer
- External incision and drainage of cellulitis
- Extraoral abscess
- Gingival hyperplasia
- Intraoral abscess
- Loss of jaw substance due to direct trauma or treatment of neoplasm
- Mercury hypersensitivity
- Myofascial pain dysfunction syndrome
- Orthodontia care as a result of a cleft palate

What IS NOT Covered (not all-inclusive)

- Bridges (adding or modifying)
- Dental carries (decay)
- Dentures or partial dentures (adding or modifying)
- Examinations (routine, general health)
- Fillings
- Injuries (trauma) to teeth only
- Orthodontia care (braces) except related to the medical or surgical correction of a cleft palate
- Root canals
- Treatment of generally poor dental health

Durable Medical Equipment (DME)

DME is equipment that can withstand repeated use; is primarily used to serve a medical purpose; is generally not useful in the absence of an illness or injury; and is appropriate for use in the home. DME includes such items as a wheelchair or a hospital bed.

The DME must be ordered by a physician and be preauthorized by us if the total cost (for rental or purchase) exceeds $300. Preauthorization allows us to purchase the DME through the Veterans Affairs (VA) at a discounted rate. There is no cost share if the DME is preauthorized and obtained through a VA source. Requests for preauthorization must include the doctor's DME order or certificate of medical necessity. This information can be submitted in the form of a letter or by using a Medicare certificate of medical necessity form. In either case, the following information must be included:

- the name, address, and tax identification number of the provider,
- the required equipment (the make and model number, cost and specifications for any customization),
- diagnosis,
- the medical necessity, and
- the anticipated duration that the item is needed.

In the case of an emergency, immediate rental will be authorized from a local supply center until the equipment can be provided through VA sources. In urgent need situations (such as being discharged from the hospital to the home and requiring a hospital bed), preauthorization may be requested by phone. If purchase of the equipment is required, rental can be approved while the purchase of the equipment is arranged through the VA. A certificate of medical necessity is still required.

If you have Medicare coverage and the DME needed is a covered benefit under Medicare, you do not need to obtain preauthorization from us.

What IS Covered (not all inclusive)

- Customization, accessories, or supplies that are essential to provide a therapeutic benefit and to ensure proper functioning of the equipment
- DME that is prescribed by a physician for the treatment of a covered illness or injury and provides the necessary level of performance
- Duplicate item of DME when it is essential to provide a fail-safe, in-home, life-support system
- Maintenance by a manufacturer's authorized technician
- Repair and adjustment
- Replacement needed as a result of normal wear or a change in the medical condition

- Temporary rental when the purchased DME is being repaired
- Vehicle wheelchair lift (detachable)

What IS NOT Covered (not all-inclusive)

- Exercise equipment
- Hearing aids or other communication devices
- Hot tubs
- Household and recliner chairs
- Luxury or deluxe equipment (CHAMPVA covers only the cost of basic equipment that meets your medical needs)
- Maintenance agreements/contracts
- Repair and adjustment costs on rented/leased equipment (Those costs should be included in the rental/lease agreements.)
- Spas
- Swimming pools
- Vehicle lifts that are non-detachable and/or manufactured for a specific vehicle that cannot be removed from one vehicle and used on another
- Whirlpools

Family Planning and Maternity

CHAMPVA covers most treatment related to prenatal, delivery, and postnatal care, to include complications associated with pregnancy such as miscarriage, premature labor, and hemorrhage. Services provided to the mother and those provided to the child must be billed separately.

What IS Covered (not all inclusive)

- Amniocentesis
- Care and treatment provided by free-standing or institution-affiliated birthing centers
- Care provided by certified nurse midwives
- Cesarean section
- Diaphragms (including replacements)
- Fetal fibronectin enzyme immunoassay
- Hospital and/or nursery charges
- Infertility testing and treatment
- Intrauterine devices (insertion, removal, replacement)
- Physician's care, diagnostic tests, and services
- Prescription contraceptives including Norplant
- Surgical sterilization (i.e., tubal ligation and vasectomy)
- Ultrasound related to high-risk pregnancy or neonatal complications

What IS NOT Covered (not all-inclusive)

- Abortion counseling
- Abortions except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term
- Artificial insemination
- Contraceptives not requiring a physician's prescription such as condoms, spermicidal foams, and jelly
- Diagnostic tests to determine the sex of a child
- Diagnostic tests to establish a child's paternity
- Embryo transfer
- In vitro fertilization
- Natural childbirth classes
- Postpartum home visits for non-medical reasons
- Postpartum inpatient stay of an infant for purposes of staying with the mother (when the mother requires continued treatment, but the newborn does not)
- Postpartum inpatient stay of a mother for purposes of staying with the newborn (when the newborn requires continued treatment, but the mother does not)
- Reversal of sterilization

Hospice

CHAMPVA covers hospice care for terminally ill patients who have a life expectancy of six months or less. The CHAMPVA benefit closely resembles Medicare's hospice benefit. The program is designed to provide care and comfort to CHAMPVA beneficiaries and emphasizes supportive services such as pain control, home care, and patient comfort.

Preauthorization is required. Your hospice caregiver will be asked to provide the following information:

- Hospice tax identification number
- Medicare hospice provider number
- Address of hospice
- County in which hospice is located
- Remit to address (where the payment is to be mailed)
- Name of attending physician
- Name of hospice physician
- Diagnosis
- Whether request is for inpatient, home care, or respite care
- Physician certification of terminal illness

- Patient's election of hospice (signed by patient or patient's representative based on a health care power of attorney) – forms provided by the hospice
- The Medicare hospice per diem (daily) reimbursement rate
- Itemized list of medications not included under hospice

What IS Covered (not all inclusive)

- Counseling for patient and caregiver
- Custodial care
- Dietary counseling
- Home health aide services under the supervision of a registered nurse (Nursing notes and the treatment plan must be provided with the billing.)
- Medical social services by a qualified social worker under the direction of a physician
- Medical supplies that are part of a written plan of care
- Personal comfort items related to pain relief
- Pharmaceuticals (drugs) primarily for the relief of pain and control of symptoms related to the terminal illness
- Respite care (Furnished in a facility such as a hospital or in the home. The purpose is to relieve the patient's caregiver from the day-to-day patient care tasks. Respite care is of limited duration.)
- Short-term inpatient care, both respite and general care, provided in a Medicare participating hospice inpatient unit, hospital, or skilled nursing facility
- Therapy (physical, occupational, speech-language pathology services) provided to control symptoms or to enable activities of basic living and basic functional skills

Inpatient Services

What IS Covered (not all-inclusive)

General:

- Intensive care
- Private room and board when medically necessary
- Semi private room and board

Surgical Services:

- Anesthesia services (performed by other than the operating surgeon, obstetrician, or assistant surgeon)
- Diagnostic procedures which require sedation or anesthesia, such as endoscopies and biopsies

- Gastric bypass, gastric stapling, gastroplasty (limitations apply, medical documentation must be submitted with billing)
- Invasive procedures, including treatment of fractures and dislocations
- Panniculectomy to correct body function (not for cosmetic purposes, limitations apply, medical documentation must be submitted with billing)
- Surgical procedures for a covered diagnosis (to include pre and post operative care)

Inpatient Professional Services:

- Attending physician (includes physician care/visits received in a hospital or other specialized facility for a covered diagnosis)
- Chemotherapy
- Concurrent inpatient care (a physician's care of a patient confined in a hospital when required to treat another condition outside the specialty of the primary care physician)
- Diagnostic tests and procedures
- Patient-initiated second opinion consultation to determine medical necessity
- Physician specialist consultations requested by the attending physician
- Surgical assistant, if required by the complexity of the surgical procedure being performed (supporting medical documentation must be submitted with the billing)

What IS NOT covered (not all-inclusive)

- Cosmetic surgery performed to improve physical appearance or for psychological purposes
- Custodial care, retirement or rest homes, halfway houses, and domiciliaries (house or place of permanent residence)
- Personal comfort items such as telephones and televisions
- Services/supplies that could have been (and are) performed routinely on an outpatient basis
- Staff consultations required by the policies of a hospital or other institution
- Surgery for psychological reasons
- Telephone consultation

Mental Health Services

Preauthorization is required for most mental health and substance abuse services. Requests for preauthorization are to be made to the CHAMPVA mental health contractor, Magellan Behavioral Health (see *Preauthorization* section). Institutional providers rendering care in residential treatment centers (RTC), psychiatric partial hospitalization facilities (PHP), and free-standing substance abuse rehabilitation

facilities must be on a TRICARE approved provider listing or be a Medicare certified facility.

Any independent mental health provider who is appropriately licensed and/or certified may provide mental health services.

Providers who may render care without an attending physician's referral and supervision are:

- Certified Psychiatric Nurse Specialist
- Clinical Psychologists
- Family Counselors
- Licensed/Certified Clinical Social Workers (Master's Level)
- Medical Doctors (MDs)
- Osteopaths (DO)
- Psychiatrists

Providers requiring a physician's referral and supervision include:

- Mental Health Counselors
- Pastoral Counselors

MENTAL HEALTH INPATIENT CARE

What IS Covered (not all-inclusive)

- Acute care to include room, board, and other hospital services - preauthorization is required from the CHAMPVA mental health contractor
- 30 days for beneficiaries ages 19 and over, per fiscal year (October 1 through September 30) or during a single episode of care
- 45 days per fiscal year for acute inpatient care for beneficiaries ages 18 or younger
- One psychotherapy session per day not to exceed seven (7) sessions per week (More than seven (7) sessions per week requires authorization from the mental health contractor.)

The CHAMPVA mental health contractor may consider a waiver of the 30/45-day limit.

What IS NOT Covered (not all-inclusive)

- Cosmetic surgery performed for psychological reasons
- Inpatient stay to primarily control or detain a runaway child
- Outpatient psychotherapy provided while a beneficiary is participating in an inpatient program

MENTAL HEALTH OUTPATIENT CARE

What IS Covered (not all-inclusive)

- 23 outpatient psychotherapy sessions per fiscal year (October 1 – September 30) when medically necessary.
- Two psychotherapy sessions per week in any combination of individual, family, collateral or group.
- More than 23 visits per year and more than two visits per week when preauthorized by the CHAMPVA mental health contractor.
- Individual psychotherapy (limited to 60 minutes unless for crisis intervention).
- Individual psychotherapy sessions in excess of 60 minutes that have been preauthorized by the CHAMPVA mental health contractor.
- Multiple sessions on the same day to allow for crisis intervention and preauthorized by the CHAMPVA mental health contractor.

What IS NOT Covered (not all-inclusive)

- Multi-family group therapy
- Sex therapy counseling or sexual behavior modification

PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAM (PHP)

What IS Covered (not all-inclusive)

- 60 days per fiscal year (October 1 – September 30) - preauthorization is required from the CHAMPVA mental health contractor
- A program that is at least 3 hours per day, and available 5 days per week (day, evening, or weekend program)

What IS NOT Covered (not all-inclusive)

- Outpatient psychotherapy while a beneficiary is participating in a partial hospitalization program (PHP)
- Services billed separately by the institutional provider (PHPs are paid based on an all-inclusive per diem rate.)

RESIDENTIAL TREATMENT CENTER (RTC)

What IS Covered (not all-inclusive)

- 150 days per fiscal year (October 1 – September 30) - preauthorization is required by the CHAMPVA mental health contractor at least two days before admission
- Care in a TRICARE- authorized facility
- Care for adolescents ages 18 and younger (or under the age of 21 if a full-time student)
- Care when a psychiatrist recommends admission for a diagnosable psychiatric disorder and a psychiatrist or clinical psychologist directs the treatment plan. Note: the treatment plan must include a provision for family therapy.
- Geographically Distant Family Therapy (GDFT) when preauthorized by the mental health contractor

What IS NOT Covered (not all-inclusive)

- Admissions primarily for substance use disorder rehabilitation
- Therapeutic absences

MENTAL HEALTH SUBSTANCE ABUSE BENEFITS

Under CHAMPVA, you are entitled to three (3) substance use disorder treatment benefit periods in your lifetime. A benefit period begins with the first date of covered treatment and ends 365 days later (regardless of the total services actually used within that one-year benefit period).

What IS Covered (not all-inclusive)

- Outpatient rehabilitation
  - 60 group therapy sessions for outpatient rehabilitation, when medically necessary, per benefit period (individual therapy is not covered for Substance Use Disorder Rehabilitation)
  - 15 sessions per benefit period for family therapy provided on an outpatient basis

- Detoxification
  - Inpatient services for detoxification. Preauthorization is required by the CHAMPVA mental health contractor
  - Limited to 7 days per admission and counts toward the 30/45-inpatient mental health day limit.
  - Detoxification can only be approved if care is under general medical supervision.

- Inpatient and Partial Hospitilization Rehabilitation
    - Preauthorized services as approved by the CHAMPVA mental health contractor.
    - Limited to no more than one inpatient stay during a single benefit period of 21 days.
    - Limited to three benefit periods or rehabilitation stays per lifetime.

What IS NOT Covered (not all-inclusive)

- Aversion therapy
- Domiciliary care/services including halfway houses and rest cure facilities

OTHER MENTAL HEALTH BENEFITS

What IS Covered (not all-inclusive)

- Attention Deficit Hyperactivity Disorder (ADD or ADHD)
- Crisis Intervention: individual psychotherapy over 60 minutes or family therapy over 90 minutes. Preauthorization is required from the CHAMPVA mental health contractor.
- Eating disorders. Preauthorization is required from the CHAMPVA mental health contractor.
- Electroconvulsive Therapy (ECT)
- Psychotropic pharmacological management
- Psychological testing, limited to 6 hours per fiscal year (October 1 through September 30). Preauthorization is required from the CHAMPVA mental health contractor for testing over six hours.
- Psychoanalysis provided by a graduate or candidate of a psychoanalytic training institute recognized by the American Psychoanalytic Association. Preauthorization is required from the CHAMPVA mental health contractor.

What IS NOT Covered (not all-inclusive)

- Acupuncture/acupressure
- Biofeedback for ordinary muscle tension or psychosomatic conditions
- Carbon dioxide therapy
- Care for antisocial behavior
- Care for specific development disorders, learning disabilities, and other conditions not attributable to a mental health disorder
- Care or supplies furnished or prescribed by a person in the immediate family
- Counseling/self-help services, i.e., nutritional counseling, stress

management, lifestyle modifications, counseling services related to tobacco use, safe sexual practices
- Court-ordered treatment in which the patient is directed to a specific treatment provider, and the treatment program is available at no cost to the beneficiary
- Drug maintenance programs where one addictive drug is substituted for another, such as methadone for heroin
- Electroshock therapy (EST) as negative reinforcement
- Eye movement desensitization reprocessing (EMDR)
- General or special education
- Guided imagery
- Holistic therapy (such as bioenergetics and orthomolecular therapies)
- Hypnosis
- Learning disorders such as reading disorders or dyslexia, mathematics disorders, disorders of written expression/and or learning disorders not otherwise specified
- Light therapy for seasonal affective disorder (SAD)
- Marathon therapy
- Marriage counseling
- Megavitamin therapy
- Mind expansion or elective psychotherapy, i.e., Z therapy and transcendental meditation, environmental ecological treatments, primal therapy
- Multi-family group therapy
- Narcotherapy with LSD
- Psychotherapy within 24 hours of electroconvulsive therapy (ECT) or electroshock therapy (EST)
- Rolfing
- Services by a provider who is not licensed/certified for the service being provided
- Sexual dysfunction, paraphilias and gender identity disorders
- Telephone consultations
- Test of variables of attention (TOVA) to diagnose ADD/ADHD

Pharmacy Services

Local Retail Pharmacy: You can choose any pharmacy. The CHAMPVA Authorization Card is your proof of coverage. Advise the pharmacy that CHAMPVA does not have a special drug coverage card for prescriptions. When using a local retail pharmacy, you may request reimbursement from us by submitting a CHAMPVA Claim Form VA Form 10-7959a, the itemized pharmacy statement (see *Claim Filing Requirements* in this handbook), and the explanation of benefits statement from any other health care plan that may have paid on the claim.

Meds by Mail: If you have submitted a current CHAMPVA Other Health Insurance Certification that supports that you do not have another health insurance plan with pharmacy coverage, you can use Meds by Mail for your non-urgent, maintenance medication needs. There are **no co-payments, no deductible requirements, and no claims to file!** Prescribed maintenance medication is mailed to your home. Registration forms are available from the website at www.va.gov/hac by selecting FORMS from the left panel. You can also receive more information by clicking on the Meds by Mail link from the left panel on the same web page. Forms can also be requested from 1-800-733-8387 and they will be mailed to you. This program is a great benefit and we highly encourage its use.

Medical Matrix Network Pharmacies: Many pharmacies use the billing agent, Medical Matrix, that has over 45,000 pharmacies in its network. If you have submitted a CHAMPVA Other Health Insurance Certification Form and do not have another health insurance plan that includes pharmacy coverage, you can use this network of pharmacies. The advantage to you is that you need only pay your cost share for the medication (after your outpatient deductible has been met) and there are no claims to file. To obtain information on local pharmacies in your area that are a part of the Medical Matrix network of pharmacies, you may access our website at www.va.gov/hac. Use the following instructions:

- Click on *Medical Matrix* in the blue section on the left.
- A paragraph will appear entitled, *Medical Matrix,* go to the end of the paragraph and click on Click Here.
- A page will appear with a box requesting *Pharmacy Service Type,* select CHAMPVA Only.
- Fill in your *Postal Zip Code.*
- Fill in *Sort by:* (this will allow you to select, store name, address, city and telephone number of your pharmacy).
- Click on *Locate Pharmacy* and a listing will appear.
- If nothing appears in your postal area, click below the page where it states *Click here to search beyond your area.*

For those of you who do not have access to a computer, call Medical Matrix at 1-800-880-1377 and ask for names of pharmacies in your area that are a part of their network.

What IS Covered (not all inclusive)

- Drugs and medications, whether administered by a physician or obtained by prescription, are covered when all of the following are met:
  - Drug has a valid National Drug Code (NDC)
  - Drug is approved by the Department of Health and Human Services' Food and Drug Administration (FDA) for the treatment of the condition for which it is administered

  - Drug is medically necessary and appropriate for the treatment of the covered condition for which it is administered
  - Drug is prescribed by an authorized provider and dispensed in accordance with state law and licensing requirements
- Insulin and diabetic related supplies (covered even though a prescription may not be required by State law)
- Oxygen and related supplies (to include oxygen concentrators)
  - Preauthorization is not required.
  - A certificate of medical necessity is required that includes the oxygen flow rate with frequency and duration of use, estimated length of time oxygen will be required, and the method of delivery. A Medicare certificate of medical necessity can be used or the physician can provide this information on his/her letterhead.
  - If the initial certificate of medical necessity shows an indefinite or lifetime need, a new prescription is not required with each billing as long as the diagnosis supports a continued need.

What IS NOT Covered (not all-inclusive)

- Drug maintenance programs where one addictive drug is substituted for another (such as methadone for heroin)
- Experimental or investigational drugs that are not approved by the FDA for commercial marketing
- Group C drugs for terminally ill cancer patients (these medications are available free from the National Cancer Institute through its registered physicians)
- Over-the-counter medications that do not require a prescription (except for insulin and diabetic related supplies which are covered even when a physician's prescription is not required under State law)
- Smoking cessation medication and products
- Weight control medication

Preventive Health Care

Preventive care includes diagnostic and other medical procedures for periodic health screenings that are not directly related to a specific illness, injury, or definitive set of symptoms.

What IS Covered (not all-inclusive)

- Cancer screenings to include colorectal, oral cavity, prostate, skin, testicular, breast, and thyroid
- Chest x-rays prior to undergoing an inpatient surgical procedure involving general anesthesia

- Cholesterol screening
- Electrocardiograms (ECG) prior to undergoing an inpatient surgical procedure involving general anesthesia
- Genetic testing and counseling during pregnancy for any of the following
  - women 35 years of age or older
  - one parent has had a previous child born with a congenital abnormality
  - one parent has a history (personal or familial) of congenital abnormality
  - mother contracted rubella during first trimester of pregnancy
  - history of cystic fibrosis or recessive genetic disorder
- HIV testing in cases of HIV exposure or symptoms of infection
- Immunizations (see following charts which note an X under the age recommended by the Center for Disease Control for each immunization)

RECOMMENDED IMMUNIZATION SCHEDULES

Age → Vaccine ↓	Birth	1 Mo.	2 Mos.	4 Mos.	6 Mos.	12 Mos.	15 Mos.	18 Mos.	4-6 Yrs.	11-12 Yrs.	14-16 Yrs.
Hepatitis B1	X	X	X								
B2		X	X	X							
B3					X	X	X			X	
Diphtheria, tetanus, pertussis (DTP)			X	X	X	X	X	X	X	X	X
H influenza type b			X	X	X	X	X	X	X		
Polio virus			X	X	X	X	X	X	X		
Measles, mumps, and rubella						X	X		X	X	X
Varicella virus						X	X	X		X	

Age → Vaccine ↓	18-24 yrs	25-64 yrs	65+ yrs
Influenza	X	X	X
Pnuemococcal	X	X	X
Measles	X	X	
Mumps	X	X	
Rubella	X	X	
Varicella	X	X	X
Td	X	X	X
Polio	X	X	
Hepatitis B-4	X	X	X

- Isoniazid therapy for individuals at high risk for tuberculosis
- Mammograms and x-ray mammography routine screening (medical documentation is required with the billing to show high risk—such as family history of breast cancer, personal history of breast cancer, benign breast disease)

Age	No Symptoms	High Risk
35-40	One Baseline	Yearly
40-50	Every other year	Yearly
50+	Yearly	Yearly

- Pap screenings for patients age 18 and older or those younger than 18 when recommended by a clinician
- Physical exams (school-required for enrollment) for students through the age of 17
- Rabies vaccine following an animal bite
- Rh immune globulin when administered to an Rh negative woman during pregnancy and following the birth of an Rh positive child
- Tetanus immune globulin (human) and tetanus toxoid
- Tuberculosis screening
- Well-child care up to 6 years of age - each office visit may include:
  - history and physical exam
  - developmental and behavioral appraisal
  - sensory screening (vision/hearing)
  - dental screening (dental work requires preauthorization)
  - heredity and metabolic screening
  - immunizations
  - hemoglobin or hematocrit testing
  - urinalysis
  - blood lead test
  - health guidance and counseling (including breast feeding and nutrition counseling)

What IS NOT Covered (not all-inclusive)

- Counseling services related to tobacco use, safe sexual practices, dental health, etc.
- Employment required examinations
- Eye/vision examinations unless required in connection with a covered illness/injury
- Hearing examinations unless in connection with a covered illness/injury
- Pre-employment physicals
- Routine physical examinations unless related to well-child care or school-required physicals for students through age 17

Skilled Nursing Facility Care

A skilled nursing facility (SNF) provides skilled nursing or rehabilitative care to patients who need 24 hour per day care under the supervision of a registered nurse or physician. A service is considered skilled care when it cannot be done by a non-medical person (or yourself) after reasonable instructions. Skilled care may be provided in a facility that is separate from a hospital or it may be a distinct part of a hospital. Skilled nursing does not require preauthorization, but all claims are subject to medical review. Claims should be accompanied by medical documentation that justifies that level of care on a daily basis. SNF care is limited to periods that are documented to clearly show this level of care is medically necessary and appropriate.

Transplants

Transplants must be preauthorized. A summary from the transplant team indicating the medical necessity and any contraindications for the procedure must be provided with the request for authorization.

What IS Covered (not all-inclusive)

- Allogeneic bone marrow transplantation
- Autologous bone marrow transplantation
- Corneal transplantation
- Donor costs when:
  - Both the donor and recipient are CHAMPVA beneficiaries
  - The donor is a CHAMPVA beneficiary and the recipient is not a CHAMPVA beneficiary
  - The donor is the sponsor and the recipient is the beneficiary (In this case, donor costs are paid as part of the recipient costs.)
  - The donor is not a CHAMPVA beneficiary, but the recipient is a CHAMPVA beneficiary
- Heart transplantation
- Heart-kidney transplantation
- Heart-lung transplantation
- Kidney transplantation
- Liver transplantation
- Liver-kidney transplantation
- Lung transplantation
- Multivisceral transplantation
- Pancreas-kidney transplantation
- Peripheral stem cell transplantation
- Small intestine transplantation
- Small intestine-liver transplantation
- Umbilical cord blood stem transplantation

What IS NOT Covered (not all-inclusive)

- Pancreas transplantation (unless performed at the same time as a kidney transplant)

Cost and Payment Information

Department of Veterans Affairs
Health Administration Center
CHAMPVA

Overview

YOUR COSTS

There are two parts to your costs. First, for outpatient care (for example, pharmacy and doctor's appointments), there is an annual deductible. Second, most medical services and supplies have a cost share (co-payment).

ANNUAL DEDUCTIBLE

The annual (calendar year) outpatient deductible is the amount that you must pay before CHAMPVA pays for a covered outpatient medical service or supply. The deductible is $50 per beneficiary or a maximum of $100 per family per year. The annual deductible must be paid prior to CHAMPVA paying 75% of the allowable amount. As claims are processed for covered services, charges are automatically credited to individual and cumulative family deductible requirements for each calendar year. Do NOT send checks to CHAMPVA to satisfy your deductible requirement.

There is no deductible for inpatient services, ambulatory surgery facility services, partial psychiatric day programs, hospice services, services provided in VA CITI facilities, or for medications received through the Meds by Mail program.

COST SHARE

A cost share, or copayment, is the portion of the CHAMPVA-determined allowable amount that you are required to pay. With few exceptions, you will pay something toward the cost of your medical care. For covered outpatient services, CHAMPVA pays up to 75% of the CHAMPVA-determined allowable amount after the deductible is met. For your inpatient service cost share, please refer to the chart in this section entitled *CHAMPVA Costs and Payments Summary*.

There is no cost share for hospice or for services received through VA medical facilities. This includes durable medical equipment items obtained through the VA (see *Durable Medical Equipment*), services received at VA facilities under the CITI program, or medications obtained through the Meds by Mail program.

CATASTROPHIC CAP

To provide financial protection against the impact of a long-term illness or serious injury, CHAMPVA has established an annual (calendar year) limit for out-of-pocket expenses for covered services paid by each CHAMPVA-eligible family. This is the maximum out-of-pocket expense a family can incur for CHAMPVA-covered services and supplies in a calendar year. Effective January 1, 2002, the CHAMPVA catastrophic cap is $3,000 per calendar year.

Credits to the catastrophic cap are applied starting January 1st of each year and run through the end of the calendar year, December 31st. Upon meeting the limit, the beneficiary/family cost share for covered services for the remainder of the calendar year is waived, and CHAMPVA pays 100% of the allowable amount for covered services for the remainder of the calendar year.

Each time CHAMPVA pays a bill, your deductible and cost share are calculated and credited to your catastrophic cap. The cumulative amount credited to your catastrophic cap is shown on the explanation of benefits (EOB) you receive after services are paid. Although CHAMPVA automatically tracks catastrophic cap credits, you are encouraged to keep track of how much you pay in annual deductibles and the amount you pay for your covered medical expenses within the calendar year. To ensure that all applicable costs are appropriately applied, it is suggested that the EOBs be carefully reviewed for accuracy and that all inaccuracies be immediately reported to us.

CHAMPVA-DETERMINED ALLOWABLE AMOUNT

The allowable amount is the maximum payment that CHAMPVA will authorize for a covered medical service or supply. The allowable amount is determined prior to cost sharing and the application of the deductible and other health insurance payment. The CHAMPVA-determined allowable amount is equivalent to that allowed by the Department of Defense TRICARE program and Medicare for similar services.

PAYMENT IN FULL

The CHAMPVA-determined allowable amount for medical services and supplies is payment in full. The medical provider cannot bill you for the difference between the amount billed to CHAMPVA and the CHAMPVA-determined allowable amount. You are responsible, however, for payment of services and supplies that are not covered under CHAMPVA.

CHAMPVA COSTS AND PAYMENT SUMMARY

BENEFITS	DEDUCTIBLE?	YOU PAY	CHAMPVA PAYS
Ambulatory Surgery Facility Services	NO	25% of CHAMPVA allowable	75% of CHAMPVA allowable
Professional Services	YES	25% of CHAMPVA allowable after deductible	75% of CHAMPVA allowable
Durable Medical Equipment (DME) Non-VA Source	YES	25% of CHAMPVA allowable after deductible	75% of CHAMPVA allowable
Inpatient Services DRG Based	NO	Lesser of: 1) per day amount X number of inpatient days; 2) 25% of billed amount; or 3) DRG rate	CHAMPVA allowable less beneficiary cost share
Inpatient Services: Non-DRG Based	NO	25% of CHAMPVA allowable	75% of CHAMPVA allowable
Mental Health: High Volume/ RTC	NO	25% of CHAMPVA allowable	75% of CHAMPVA allowable
Mental Health: Low Volume	NO	Lesser of: 1) per day amount X number of inpatient days; or 2) 25% of billed amount	CHAMPVA allowable less beneficiary cost share
Outpatient Services (i.e. doctors visits, lab/radiology, home health, skilled nursing visits, ambulance)	YES	25% of CHAMPVA allowable after deductible	75% of CHAMPVA allowable
Pharmacy Services	YES	25% of CHAMPVA allowable after deductible	75% of CHAMPVA allowable
VA Source (DME, MbM, CITI)	NO	Nothing	100% of VA cost

Ambulatory Services

Facility charges associated with procedures performed in an ambulatory surgery setting (includes both hospital-based settings and free-standing surgical centers) are based on a payment system in which a fixed rate for the surgical procedure is adjusted for local costs. CHAMPVA pays 75% of the allowable amount for costs incurred in this type of facility and you pay 25%. The allowable for ambulatory surgery is the lesser of the CHAMPVA established maximum allowable amount or the billed charge.

Dental Services

For authorized dental services, CHAMPVA pays 75% of the allowable amount after the deductible has been met and you pay 25%. The allowable for dental services is the lesser of the CHAMPVA established maximum allowable amount or the billed charge.

Durable Medical Equipment

Durable Medical Equipment (DME) obtained through the VA: CHAMPVA pays the full cost for covered items obtained through a VA source. There is no cost to you (no cost share or deductible).

DME obtained through a local supplier: The CHAMPVA-determined allowable for DME is the lesser of the maximum allowable amount or the billed charge. CHAMPVA will pay 75% of the allowable amount after the deductible is met and you pay 25%.

NOTE: As described in the *Benefit Information* section, preauthorization is required for all durable medical equipment (DME) with a purchase price or total rental cost of $300 or more. In addition to confirming medical necessity, the DME preauthorization process affords us the opportunity to determine the most economical source for purchasing the required equipment.

Home Health Care

CHAMPVA pays 75% of the allowable amount after the outpatient deductible is met for covered services and you are responsible for the remaining 25%. The allowable is the lesser of the CHAMPVA established maximum allowable amount or the actual billed charge.

Hospice Services

There is no deductible and no cost share requirement for hospice services. The CHAMPVA allowable amount is based on national Medicare rates for hospice services. There are Medicare pre-determined rates for routine home care; continuous home care; inpatient respite care; and general inpatient care. These rates are updated yearly.

Separate payments are made for direct patient care services provided by an attending physician.

Inpatient Services

An inpatient service occurs when the admission to a hospital is for 24 hours or more, or when the admission was intended to last for more than 24 hours. There is no deductible requirement for inpatient services.

Facility Charges:

- CHAMPVA uses a Diagnostic Related Group (DRG) payment system to calculate the cost for most inpatient hospital services provided. This payment system is based on an episode of care. The DRG payment rates are based on an average cost of local care and the allowable amount may be either more or less than the billed amount. This is generally equivalent to the DoD TRICARE or Medicare rate.

- Under this system, CHAMPVA pays the allowed amount less your cost share. You pay the lesser of:
  - the annual adjusted per day amount multiplied by the number of inpatient days, or
  - 25% of the hospital's billed charges, or
  - the DRG rate.

- The DRG rate does not apply to all inpatient facilities. DRG rates are not applicable to cancer hospitals, Christian Science sanitoriums, foreign hospitals, long-term hospitals, non-Medicare participating hospitals, skilled nursing facilities, rehabilitation hospitals, and sole community hospitals (that have a special exemption from Medicare). When the DRG rate does not apply, CHAMPVA pays 75% of the billed amount for covered services and supplies and you pay 25%.

Professional Services:

- These services include physicians' fees and anesthesia services. The CHAMPVA-determined allowable is the lesser of the CHAMPVA established maximum allowable amount or the billed charge. CHAMPVA pays 75% of the allowed amount and you pay 25%.

Mental Health Services

The allowable amount for inpatient care in psychiatric hospitals and discrete psychiatric units within hospitals that do not use the DRG payment system is based on a daily rate. The daily rate is based on locally determined costs. High volume and low volume treatment centers may bill differently for services. A facility in which a large number of CHAMPVA beneficiaries are treated would be considered a high volume center while a center that sees few CHAMPVA beneficiaries would be considered a low volume facility.

High Volume: Your cost share for care in a high volume facility (a facility with a combined total of more than 25 CHAMPVA and TRICARE admissions per year) is 25% of the CHAMPVA allowable amount. This includes residential treatment centers (RTCs). The allowable amount is the lesser of the facility specific fixed daily rate multiplied by the number of authorized days in the facility or the billed charge.

Low Volume: Your cost share is the lesser of 25% of the billed amount or a per day amount times the number of inpatient days. The allowable amount is the lesser of the annually adjusted regional fixed daily rate multiplied by the number of covered inpatient days or the billed amount.

Professional Services: There are other charges for services that may not be included in the daily rate charges such as physician's services. You are responsible to pay 25% of the allowable amount. The allowable amount of these services is the lesser of the CHAMPVA established maximum allowable amount or the actual billed charge.

Outpatient Services

After the deductible has been met, CHAMPVA will pay 75% of the allowable amount for covered services and you are responsible for the remaining 25%. The allowable amount for outpatient services is the lesser of the CHAMPVA established maximum allowable amount or the actual billed charge.

Pharmacy Services

Medications obtained from a local pharmacy: The CHAMPVA allowable amount for pharmacy services is the average wholesale price (AWP) plus a $3.00 dispensing fee. CHAMPVA pays 75% of the allowable amount after the deductible has been met and you pay 25%. If you go to a local retail pharmacy, that is not part of the Medical Matrix network (see *Pharmacy Services* in the Benefits section), the pharmacy may have you pay 100% of the bill and you will then need to submit the claim to us for reimbursement. If you go to a local pharmacy that is part of the Medical Matrix network, you will be required to pay 25% of the cost (after your deductible has been met) at the time you pick up the prescription and the pharmacy will bill us for the remainder of the cost.

Medications obtained through Meds by Mail: CHAMPVA pays the full cost of covered prescriptions. There is no cost to you.

Medications obtained through VA medical facilities that participate in the CITI program: CHAMPVA pays the full cost of covered prescriptions. There is no cost to you.

Skilled Nursing Facility Care

CHAMPVA pays 75% of the allowed amount for covered services and supplies and you pay 25%.

Other Health Insurance (OHI)

Other health insurance (OHI) is another health plan that you may have through your employer, your spouse's employer, or other government program such as Medicare. Claims involving a payment from another health insurance plan may result in reduced costs to you or, depending on the combined OHI and CHAMPVA payment, no cost share at all. You or the provider must file the claim with the other insurance plan before submitting it to CHAMPVA for payment. CHAMPVA is always the secondary payer (by law) unless you are receiving care under Medicaid, State Victims of Crime Compensation Program, or you have a CHAMPVA supplementary insurance policy. In these cases, CHAMPVA will pay first. Upon receiving the explanation of benefits (EOB) statement from the other insurer, you or the provider may file a CHAMPVA claim for any remaining balance. In addition to the EOB from the other health insurance, claims (billings) must include the provider's itemized billing statement. Please ensure all documents are legible.

DEFINITIONS

Primary Payer: A health insurance plan that will pay first on the bills for service. These are typically major medical health plans.

Secondary Payer: A health insurance plan that pays after the primary payer has determined what they will pay on the claim.

Supplemental Insurance: A health insurance plan that pays after the primary payer has determined what they will pay on the claim. CHAMPVA will pay before a CHAMPVA supplemental policy, but will pay after a Medicare supplemental policy. For more information, see the *Supplemental Health Insurance* section.

Coordination of Benefits: CHAMPVA must be aware of other health insurance to know when there may be double coverage. Knowing this, we can ensure that there is not a duplication of benefits paid between the other health insurance coverage and CHAMPVA. The explanation of benefits from the OHI provides the documentation for us to coordinate benefits and pay your claim appropriately.

OHI CERTIFICATION

Periodically, we ask you to complete a CHAMPVA OHI Certification Form (Form 10-7959c) and submit it to us at PO Box 65023, Denver, CO 80206-9023 or fax it to us at 1-303-331-7808. You must inform us of any change to any family member's OHI status. If the OHI is cancelled, we must be notified of this in writing immediately. OHI certification forms are available at www.va.gov/hac or by calling 1-800-733-8387. Failure to provide us accurate information regarding OHI coverage could be considered fraud. If it is determined that you had other insurance when CHAMPVA paid as the primary (first) insurer, recoupment action from you and/or the provider for the services paid will be taken. Failure to provide OHI certification will result in denial of CHAMPVA claims.

CHAMPVA AND HMO COVERAGE

If you have a health maintenance organization (HMO) plan, CHAMPVA will cost share your out-of-pocket expenses (your copayments under the HMO). When medical services are available through your HMO and you choose to obtain care outside the HMO (for example, from a physician who is not associated with your HMO or you do not follow the rules and procedures of your HMO to obtain the care), we will not pay for that medical care. When submitting the OHI certification (Form 10-7959c), include a copy of the HMO copayment information/schedule of benefits.

CHAMPVA AND MEDICARE

When payment for covered services and supplies may be made under both Medicare and CHAMPVA, Medicare is the primary payer. For health care services covered under both plans, you often have no out-of-pocket expenses.

SERVICE	MEDICARE PAYS	CHAMPVA PAYS	YOU PAY
Part A - Hospital			
Hospital Stay 1-60 days	All but the Medicare copayment (for example in 2002 the Medicare copayment is $812)	Your Medicare copayment	$ 0
Hospital Stay 61-90 days	All but the Medicare copayment (for example in 2002 the Medicare copayment is $203 per day)	The CHAMPVA allowable less the Medicare payment. In most cases, this will cover the Medicare per day co-payment.	The remaining balance between the CHAMPVA payment and the Medicare co-payment. In most cases, you will have no out-of-pocket expense.
Hospital Stay 91-150 days	All but the Medicare copayment (for example in 2002 the Medicare copayment is $406 per day)	The CHAMPVA allowable less the Medicare payment. In most cases, this will cover the Medicare per day co-payment.	The remaining balance between the CHAMPVA payment and the Medicare co-payment. In most cases, you will have no out-of-pocket expense.
Hospital Stay >150 days	$ 0	Up to the CHAMPVA allowable less beneficiary cost share	25% of the amount billed or per diem rate X the number of inpatient days not to exceed the catastrophic cap of $3000.
Part A - Skilled Nursing Facility (SNF)			
	There must be a 3-day inpatient stay prior to admission to the SNF		
1-20 days	100% of Medicare allowable	The CHAMPVA allowable (billed amount) less Medicare's payment	$ 0
21-100 days	All but the Medicare copayment (for example in 2002 the Medicare copayment is $101.50 per day)	The CHAMPVA allowable (billed amount) less Medicare's payment	In most cases, $ 0
>100 days	$ 0	75% of the CHAMPVA allowable	25% of CHAMPVA allowable

SERVICE	MEDICARE PAYS	CHAMPVA PAYS	YOU PAY
Part B - Outpatient			
	(after $100 deductible met)	(after $50 deductible met)	
Outpatient medical care to include: • Office visits (doctor) • Durable Medical Equipment • Cancer screenings • Mammograms • PAP smears • Immunizations(including flu shots) • Diabetes supplies (test strips, monitors, etc.) • Diabetes self-mgmt training • Bone mass measurements	80% of Medicare allowable amount	In most cases, the CHAMPVA allowable will cover the Medicare copay and a portion of the beneficiary's Medicare outpatient deductible.	In most cases, $ 0
Clinical laboratory	100% of Medicare allowable	The CHAMPVA allowable less Medicare's payment	$ 0 *
Mental Health Visit	50% of Medicare allowable	The CHAMPVA allowable less Medicare's payment	In most cases $0
Hospice Outpatient Medications Respite care	100% of Medicare allowable All but $5 per prescription 95% of Medicare allowable	The CHAMPVA allowable less Medicare's payment	$ 0 *
Pharmacy	$ 0 (with a few exceptions)	Retail: 75% of allowable amount Meds by Mail: 100%	25% of CHAMPVA allowable amount $ 0

* Where Medicare has paid 100% of the allowable representing payment in full, in most cases, there will be no out-of-pocket expense for you.

Additionally, please note the following:

- The full Medicare inpatient deductible for the first 60 days is covered by CHAMPVA.
- CHAMPVA will cover a portion of your Medicare outpatient deductible.
- For health care services payable only under one plan, and not both, you will continue to be responsible for payment of the applicable Medicare or CHAMPVA cost share and deductible.
- Custodial care is not covered under CHAMPVA.
- Medicare Part B premiums are not covered by CHAMPVA.

CHAMPVA AND MEDICAID

Whenever you are also eligible for Medicaid, CHAMPVA becomes the primary payer. In those instances where Medicaid may have made payment for medical services and supplies first, we will reimburse the appropriate Medicaid agency for the amount we would have paid in the absence of Medicaid benefits or the amount paid by Medicaid, whichever is less.

CHAMPVA AND STATE VICTIMS OF CRIME COMPENSATION PROGRAMS

CHAMPVA is always the primary payer for services that you are eligible for under a State Victims of Crime Compensation Program.

CHAMPVA AND WORKERS' COMPENSATION

CHAMPVA does not cover medical services and supplies provided to treat a work-related illness or injury when benefits are available under a workers' compensation program. It is your responsibility to apply for workers' compensation benefits. If you exhaust available workers' compensation benefits, we will make payment for covered services and supplies. Provide a copy of the final disposition of the Workers' Compensation claim to avoid any delay in payment of future claims.

CHAMPVA AND THIRD PARTY INSURANCE

CHAMPVA is a secondary payer in all instances where there is third party liability. For example, if you are involved in an automobile accident you are required to file a medical claim with your (or responsible party's) automobile insurance before submitting it to us. Upon receiving the explanation of benefits (EOB) statement from the automobile insurance company, you may file a CHAMPVA claim for any remaining balance. To ensure your medical needs are met, CHAMPVA will provide payment for medically required services while a determination of third party liability is being made. If another party is determined to be responsible for covering the bills, we will take action to collect from you or that other insurance on payments that we have made.

SUPPLEMENTAL HEALTH INSURANCE (SI)

There are a number of companies that offer CHAMPVA supplemental policies. After CHAMPVA (the primary insurance policy) makes a payment for health care services, the remaining out-of-pocket expenses such as deductibles and copayments often are payable under a supplemental insurance policy. If you have a policy that was specifically obtained for the purpose of supplementing CHAMPVA, we will compute the CHAMPVA maximum allowable amount, pay the claim, and then you can submit the claim to the supplemental insurer for payment.

CHAMPVA does not endorse one policy over another and you should carefully consider your family's needs for the additional coverage. Information on supplemental insurance is available on the HAC website at www.va.gov/hac. Further information can be obtained from the Federal Times at www.champva.com. Federal Times is not affiliated with the government and we do not endorse their products or services.

If you have a Medicare supplemental plan, please be aware CHAMPVA pays after a Medicare supplemental plan.

Claim Filing Instructions

GENERAL CLAIM FILING INSTRUCTIONS

Claims (bills for services) are to be sent to CHAMPVA, PO Box 65024, Denver, CO 80206-9024.

- Your name must be listed on the claim form exactly as it is on the CHAMPVA Authorization Card.
- Your Social Security Number must be on the claim. DO NOT USE the veteran's Social Security Number.

- If you have other health insurance (OHI), include a copy of the OHI explanation of benefits.
- Keep copies of all receipts, invoices, etc.
- Separate claim forms are required for each patient/beneficiary.
- If you do not complete CHAMPVA Claim Form 10-7959a, payment will be made directly to the health care provider instead of to you.
- For inpatient hospitalizations, payment will always be made to the hospital whether or not you submit the billing.
- After billing your other health insurance, you can file with CHAMPVA for the remaining balance.

CLAIMS SUBMITTED BY THE BENEFICIARY

Claims submitted by you must include the following:

- CHAMPVA Claim Form, VA Form 10-7959a,
- the provider's itemized billing statement to include all information listed under *Claims Submitted by the Provider*, and
- explanation of benefits (EOB) if other insurance was billed.

CLAIMS SUBMITTED BY THE PROVIDER

Claims submitted by the provider must include the following:

- An itemized billing statement. This can be submitted on a HCFA 1500 form or UB-92 form. The following information must be provided:

  - Full name, address, and tax identification number of the provider.
  - Address where payment is to be sent.
  - Address where services were provided.
  - Provider professional status (doctor, nurse, physician assistant, etc.).
  - Specific date of each service provided. Date ranges are acceptable only when they match the number of services/units of services.
  - Itemized charges for each service.
  - Appropriate code (ICD-9, CPT, HCPCS) for each service.

- If other health insurance was billed, provide a copy of their explanation of benefits detailing what they paid. Sometimes the definition/explanation of their codes is on the reverse of their explanation of benefits (please include a copy of that as well).

PHARMACY CLAIMS

Most pharmacies submit claims to CHAMPVA electronically. The following information is required for pharmacy claims regardless of whether submitted electronically or on paper and regardless of whether submitted by the pharmacy or by you:

- An invoice/billing statement that includes:
  - Name, address, and phone number of the pharmacy
  - Name of prescribing physician
  - Name, strength, quantity for each drug
  - National Drug Code for each drug
  - Charge for each drug
  - Date prescription was filled
- If the billing is submitted by you, also provide the sales receipt (cash register receipt) with the date and dollar amount that corresponds to the date and dollar amount on the pharmacy invoice/billing statement, or a signed statement from the pharmacy noting the date and amount of payment.

WHERE TO MAIL CLAIMS

Mail claims to:

VA Health Administration Center
CHAMPVA
PO Box 65024
Denver, CO 80206-9024

FILING DEADLINES

You have one year after the date of service in which to file any claims. In the case of inpatient care, the claim must be filed within one year of the discharge date. Claims submitted after the filing deadline will be denied.

HOW TO GET ADDITIONAL CLAIM FORMS

Additional claim forms can be requested at any time (including evenings and weekends) by calling us at 1-800-733-8387 and selecting the claim form option from our voice-mail menu. You can also e-mail your request to us at hac.inq@med.va.gov, or print a copy of the claim form from our website at www.va.gov/hac.

Actions on Claims

Department of Veterans Affairs
Health Administration Center
CHAMPVA

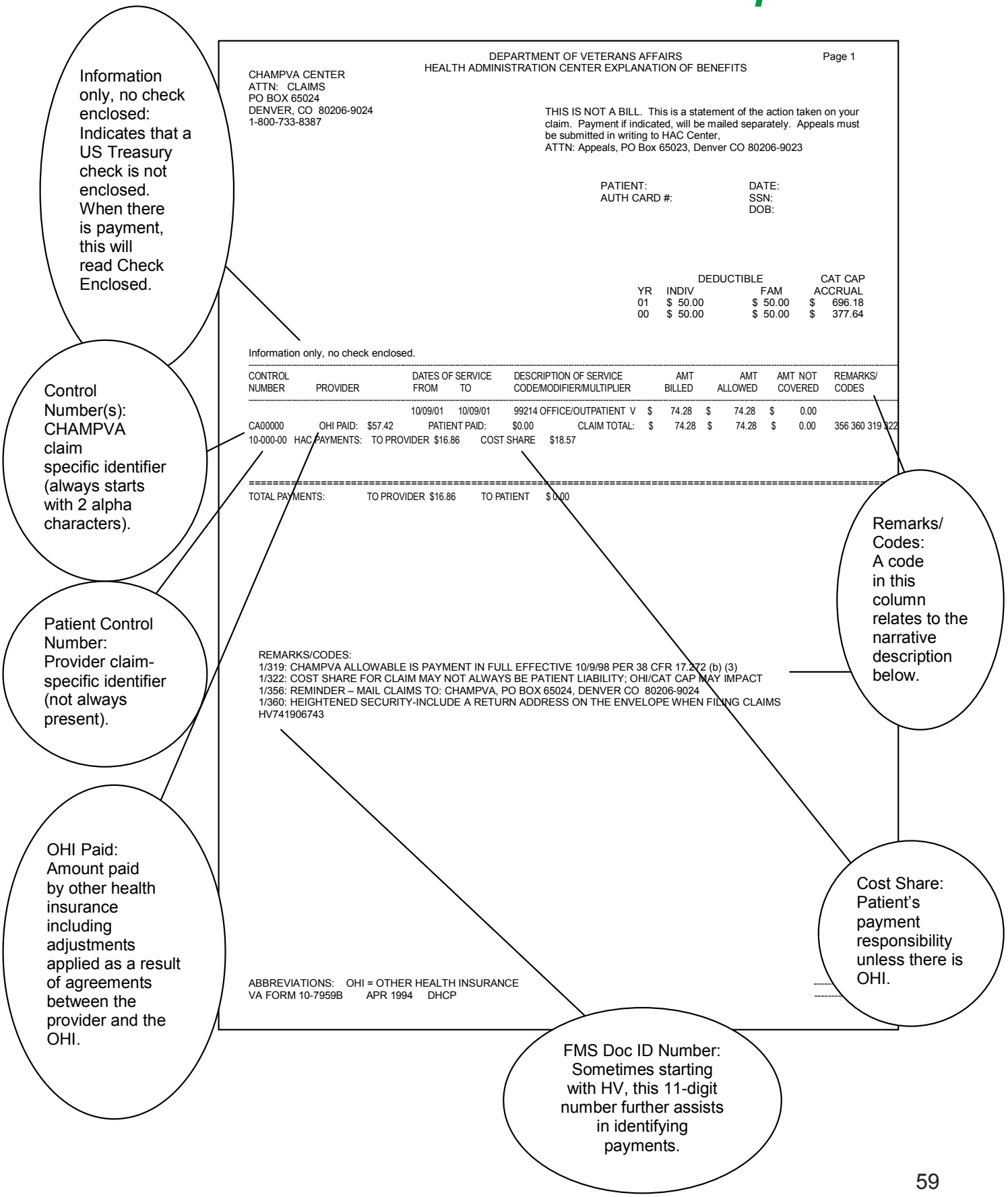
Explanation of Benefits (EOB)

The EOB is a summarization of the action taken on the claim and contains the following information:

- amount billed by the provider
- amount allowed by CHAMPVA
- amount not covered
- amount paid by other health insurance plan or program
- annual catastrophic cap accrual
- beneficiary and family deductible accrual
- CHAMPVA payment(s)
- date(s) of service
- description of service
- provider name
- remarks

When a provider files a claim, the EOB is sent to both you and the provider. When you file a claim, the EOB is sent only to you. When a DME item or other health care service is received through a VA source, an EOB is not sent to you.

Sample EOB



DEPARTMENT OF VETERANS AFFAIRS
HEALTH ADMINISTRATION CENTER EXPLANATION OF BENEFITS

Page 1

CHAMPVA CENTER
ATTN: CLAIMS
PO BOX 65024
DENVER, CO 80206-9024
1-800-733-8387

THIS IS NOT A BILL. This is a statement of the action taken on your claim. Payment if indicated, will be mailed separately. Appeals must be submitted in writing to HAC Center,
ATTN: Appeals, PO Box 65023, Denver CO 80206-9023

PATIENT:
AUTH CARD #:

DATE:
SSN:
DOB:

YR	DEDUCTIBLE INDIV	DEDUCTIBLE FAM	CAT CAP ACCRUAL
01	$ 50.00	$ 50.00	$ 696.18
00	$ 50.00	$ 50.00	$ 377.64

Information only, no check enclosed.

CONTROL NUMBER	PROVIDER	DATES OF SERVICE FROM	TO	DESCRIPTION OF SERVICE CODE/MODIFIER/MULTIPLIER	AMT BILLED	AMT ALLOWED	AMT NOT COVERED	REMARKS/ CODES
		10/09/01	10/09/01	99214 OFFICE/OUTPATIENT V	$ 74.28	$ 74.28	$ 0.00	
CA00000	OHI PAID: $57.42	PATIENT PAID: $0.00		CLAIM TOTAL:	$ 74.28	$ 74.28	$ 0.00	356 360 319 322
10-000-00	HAC PAYMENTS: TO PROVIDER $16.86	COST SHARE $18.57						

TOTAL PAYMENTS: TO PROVIDER $16.86 TO PATIENT $ 0.00

REMARKS/CODES:
1/319: CHAMPVA ALLOWABLE IS PAYMENT IN FULL EFFECTIVE 10/9/98 PER 38 CFR 17.272 (b) (3)
1/322: COST SHARE FOR CLAIM MAY NOT ALWAYS BE PATIENT LIABILITY; OHI/CAT CAP MAY IMPACT
1/356: REMINDER – MAIL CLAIMS TO: CHAMPVA, PO BOX 65024, DENVER CO 80206-9024
1/360: HEIGHTENED SECURITY-INCLUDE A RETURN ADDRESS ON THE ENVELOPE WHEN FILING CLAIMS
HV741906743

ABBREVIATIONS: OHI = OTHER HEALTH INSURANCE
VA FORM 10-7959B APR 1994 DHCP

Information only, no check enclosed: Indicates that a US Treasury check is not enclosed. When there is payment, this will read Check Enclosed.

Control Number(s): CHAMPVA claim specific identifier (always starts with 2 alpha characters).

Patient Control Number: Provider claim-specific identifier (not always present).

OHI Paid: Amount paid by other health insurance including adjustments applied as a result of agreements between the provider and the OHI.

Remarks/ Codes: A code in this column relates to the narrative description below.

Cost Share: Patient's payment responsibility unless there is OHI.

FMS Doc ID Number: Sometimes starting with HV, this 11-digit number further assists in identifying payments.

Reconsideration and Appeal Rights

DISPUTED ISSUE	RIGHT TO RECONSIDERATION?	RIGHT TO APPEAL TO BOARD OF VETERANS APPEALS?
CHAMPVA Eligibility	Yes	Yes
Payment decisions	Yes	No
Medical determinations (to include those related to mental health care)	Yes	No

DECISIONS REGARDING ELIGIBILITY

You have the right to request reconsideration or request an appeal to the Board of Veterans Appeals when we have denied your eligibility for CHAMPVA.

Reconsideration Request: Submit a letter to the VA Health Administration Center, CHAMPVA, ATTN: Appeals, PO Box 65023, Denver, CO 80206-9023 requesting reconsideration or fax the request for reconsideration to 1-303-331-7811. The request must:

- be submitted in writing within one year of the date of decision denying eligibility,
- identify why you believe the decision is in error, and
- include new and relevant information not previously submitted.

If the reason for the dispute is not identified, the request will be denied.

After reviewing the request for reconsideration and supporting documentation, a written decision will be sent to you if a change to the original decision cannot be made. If you still disagree with the decision, you may request a second review. That request for review must be made within 90 days of the date of the first reconsideration determination. Your request must be submitted in writing, identify why you believe the decision is in error, and include any further relevant information.

Appeal to the Board of Veterans Appeals: Submit a letter (also called a Notice of Disagreement) to the VA Health Administration Center, CHAMPVA, ATTN: Appeals, PO Box 65023, Denver, CO 80206-9023 requesting an appeal to the Board of Veterans Appeals. The request must be submitted in writing within one year of the date of decision denying eligibility.

We will provide you with a Statement of the Case. This is a summary of the evidence relating to the issue and the applicable laws and regulations affecting the determination. This Statement of the Case will be provided to you along with a form (VA Form 9) that provides instructions on how to file your request with the Board of Veterans Appeals.

DECISIONS ON PAYMENTS OF CLAIMS FOR MEDICAL SERVICES/SUPPLIES

You have the right to request reconsideration if you disagree with a payment decision for medical services or supplies. To do so, submit a letter to the VA Health Administration Center, CHAMPVA, ATTN: Appeals, PO Box 65023, Denver, CO 80206-9023 requesting reconsideration or fax the reconsideration request to 1-303-331-7811. The request must:

- Be submitted in writing within one year of the date of the explanation of benefits (EOB),
- Identify why you believe the payment is in error, and
- Include new and relevant information not previously submitted.

If the reason for the dispute is not identified, the request will be denied.

After reviewing the request for reconsideration and supporting documentation, a written decision will be sent to you if a change to the original decision cannot be made. If you still disagree with the decision, you may request a second review. That request for review must be made within 90 days of the date of the first reconsideration determination. Your request must be submitted in writing, identify why you believe the decision is in error, and include any further relevant information.

DECISIONS ON MEDICAL DETERMINATIONS (SUCH AS THE NEED FOR OR APPROPRIATENESS OF A SPECIFIC TREATMENT)

You have the right to request reconsideration if you disagree with a decision regarding coverage of a medical service or supply. To do so, submit a letter to the VA Health Administration Center, CHAMPVA, ATTN: Appeals, PO Box 65023, Denver, CO 80206-9023 requesting reconsideration or fax the reconsideration request to 1-303-331-7811. The request must:

- Be submitted in writing within one year of the date of the explanation of benefits (EOB),
- Identify why you believe the payment is in error, and

- Include new and relevant information not previously submitted.

If the reason for the dispute is not identified, the request will be denied.

After reviewing the request for reconsideration and supporting documentation, a written decision will be sent to you if a change to the original decision cannot be made. If you still disagree with the decision, you may request a second review. That request for review must be made within 90 days of the date of the first reconsideration determination. Your request must be submitted in writing, identify why you believe the decision is in error, and include any further relevant information.

DECISIONS ON MENTAL HEALTH MEDICAL DETERMINATIONS (SUCH AS THE NEED FOR OR APPROPRIATENESS OF A SPECIFIC TREATMENT)

First Level: You may request reconsideration from the mental health contractor (Magellan) within one year of the denial. The request must include the entire medical record and the reason for the appeal. Submit the request to Magellan Behavioral Health, CHAMPVA, PO Box 3567, Englewood, CO 80155.

Second Level: If the mental health contractor does not change the original decision to deny services, a request for reconsideration may be submitted to the Health Administration Center – CHAMPVA Program within 90 days of the mental health contractor's decision. The request must include the entire medical record and the reason for the appeal. Submit the request to the VA Health Administration Center, CHAMPVA, ATTN: Appeals, PO Box 65023, Denver, CO 80206-9023.

CHAMPVA Fact Sheet Guide

Fact sheets can be obtained from our website at www.va.gov/hac or by calling 1-800-733-8387 or sending an e-mail request to hac.inq@med.va.gov

CHAMPVA Fact Sheet Number	Title
01-1	Mental Health and Substance Use Disorder Benefits
01-2	School Certifications
01-3	Eligibility
01-4	CHAMPVA Program
01-7	General Information
01-8	Durable Medical Equipment (DME)
01-9	Pharmacy Billing Agent
01-11	Payment Methodology
01-15	Participating Providers
01-16	For Outpatient Providers And Office Managers
01-18	The CITI Program
01-22	Supplemental Insurance
01-23	Other Health Insurance
01-24	Pharmacy Benefits
01-29	CHAMPVA for Life, Medicare, Supplemental Insurance Policies and Other Related Issues

Contact Information

Department of Veterans Affairs
Health Administration Center
CHAMPVA

Applications. Where do I send my application for CHAMPVA benefits?

Mail: VA Health Administration Center
CHAMPVA
PO Box 469028
Denver, CO 80246-9028

General. Where do I find general CHAMPVA information, fact sheets, and forms?

Phone: 1-800-733-8387

Website: www.va.gov/hac

E-mail: hac.inq@med.va.gov

Inquiries. Who do I contact with questions about my benefits and bills for medical services?

Mail: VA Health Administration Center
CHAMPVA
PO Box 65023
Denver, CO 80206-9023

Phone: 1-800-733-8387

FAX: 1-303-331-7804

E-mail: hac.inq@med.va.gov

Other Health Insurance Certificates. Where do I send my completed OHI Certificate?

Mail: VA Health Administration Center
CHAMPVA
PO Box 65023
Denver, CO 80206-9023

FAX: 1-303-331-7808

Preauthorization for Dental, Durable Medical Equipment, Hospice, and Transplant Services. Who do I contact for preauthorization of these services?

Mail: VA Health Administration Center
CHAMPVA
ATTN: Preauthorization
PO Box 65023
Denver, CO 80206-9023

Phone: 1-800-733-8387

FAX: 1-303-331-7807

Preauthorization for Mental Health and Substance Abuse Counseling Services. Who do I contact for preauthorization of these services?

Mail: Magellan Behavioral Health
CHAMPVA
PO Box 3567
Englewood, CO 80155

Phone: 1-800-424-4018 (domestic)
1-720-529-7400 (international)

FAX: 1-800-424-4017

Processing of Claims. Where do I send the bills for my medical services and supplies?

Mail: VA Health Administration Center
CHAMPVA
PO Box 65024
Denver, CO 80206-9024

Requests for Reconsideration/Appeals. Who do I contact if I want to request reconsideration or appeal a decision regarding my benefits?

Mail: VA Health Administration Center
CHAMPVA
PO Box 65023
Denver, CO 80206-9023

FAX: 1-303-331-7811

Requests for Reconsideration of descisions regarding Mental Health benefits. Who do I contact if I want to request reconsideration of a descision regarding mental health benefits?

First Level

Mail: Magellan Behavioral Health
CHAMPVA
PO Box 3567
Englewood, CO 80155

Second Level

Mail: VA Health Administration Center
CHAMPVA
ATTN: Appeals
PO Box 65023
Denver, CO 80206-9023

Index

Department of Veterans Affairs
Health Administration Center
CHAMPVA

Index

U

V

W

X

Z

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Health Administration Center
CHAMPVA
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